



Kansas Department of Health and Environment
Health Occupations Credentialing
Information Inventory

For Agency Use Only	License #	Issue Date	Renewal Date	Expiration Date
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In order to obtain demographic information concerning health professionals licensed by Health Occupations Credentialing, Kansas Department of Health and Environment, all applicants are required to complete this inventory. Please print or type your responses.

Please Indicate Profession(s):

- ☐ Adult Care Home Administrator ☐ Dietitian ☐ Speech-Language Pathologist ☐ Audiologist

Name _____
Last (Gen ID) First ML Other Last Name Used

Social Security Number _____ Date of Birth ____/____/____

Mailing Address _____
Street PO/Box Apt. #

City County State Zip+4

Residence State _____ Zip+4 _____

Federal Provider ID number (if applicable) _____

Phone (work) _____ (Home) _____

Where applicable, place the letter that corresponds with your answer in the blank and provide additional information as requested.

- _____ Race
a. Caucasian
b. African American
c. Native American or Alaskan Native
d. Asian or Pacific Islander
e. Other _____
- _____ Are you of Spanish origin?
Y. Yes
N. No
- _____ Sex
M. Male
F. Female

- _____ Highest degree held
a. High school diploma or GED
b. Nursing school diploma
c. Associate Degree
d. Baccalaureate Degree
e. Masters
f. Ph.D.
g. Education specialist
h. Ed.D.

Educational Institution granting your terminal degree _____

- _____ Are you now, or have you ever been licensed in this profession in other states?
Y. Yes. If yes, list states and year granted _____
N. No

_____ Date initial license granted in Kansas.

- _____ Are you now, or have you ever held an other professional license(s) issued by Kansas or any other state or entity?
Y. Yes. If yes, list license(s), state(s), or entity _____
N. No

- _____ Employment status
a. Employed full-time in licensed profession
b. Employed part-time in licensed profession
c. Other related field (specify) _____
d. Other profession (specify) _____
e. Not employed (Do not answer any further questions. Sign and date inventory and return.)

If applicable, please indicate for your occupation:

Specialty _____
 Concentration _____
 Level _____

The Arrangement that best describes your primary and secondary employment type:

- _____ Primary a. Self-employed (own practice, partnership, consultant)
 _____ Secondary b. Employee (federal, state or local government, includes public schools, adult care home or hospital district)
 c. Employee of for profit company
 d. Employee of private non-profit organization
 e. None

What is your primary place of practice?

Facility/Setting/Institution/Agency _____

Address _____ City _____ County _____ State _____ Zip+4 _____

Please list the secondary and tertiary practice locations:

City _____ County _____ State _____ Zip+4 _____

Secondary _____

Tertiary _____

Dietitians and Speech-Language Pathologist or Audiologists, please see Occupational Addendum for additional locations.

Use number from list below to indicate place of practice then indicate type of function in each place of practice. If you function in more than one position in the place of practice, indicate those functions in columns 1, 2, and 3, as needed; indicate hours allotted to that function each week. Total number of hours in each place of practice must total an average working week.

- | <u>Place of Practice</u> | | <u>Type of Function</u> |
|--------------------------|--------------------------|-------------------------|
| 1. Residential Care Home | 5. Home Health Agency | 1. Consult |
| 2. Hospital | 6. Physician's Office | 2. Clinical |
| 3. Government Agency | 7. Clinic | 3. Management |
| Federal, State, County, | 8. Outpatient Rehab Ctr. | 4. Educator |
| City | 9. Private Industry | 5. Other |
| 4. Community Agency | 10. Educational Facility | |

Rank of Practice	Place of Practice	% of time	1. Type of Function	Estimate hours per week	2. Type of Function	Estimate hours per week	3. Type of Function	Estimate hours per week
Primary								
Secondary								
Tertiary								
Other								
Totals		100%						

I hereby attest that the information supplied in this inventory and addendum is accurate and complete to the best of my knowledge.

Applicant's Signature _____

Date _____

Return completed inventory and addendum to:

Health Occupations Credentialing
 Curtis State Office Building
 1000 SW Jackson, Suite 200
 Topeka KS 66612-1365

Occupational Addendum
Adult Care Home Administrator

The following questions are specific to your field of practice. Please answer these items and return this addendum with the completed Information Inventory.

To which associations do you belong? Check all that apply.

- ☐ American Association of Homes and Services for the Aging (AAHSA)
- ☐ American Association of Health Care Administrators (AAHCA)
- ☐ American College of Health Care Administrators (ACHHCA)
- ☐ Kansas Association of Homes and Services for the Ages (KAHSA)
- ☐ Kansas Health Care Association (KHCA)
- ☐ Kansas College of Health Care Administrators (KCHCA)
- ☐ Kansas Professional Nursing Home Administrators Association (KPNHAA)

I verify that the above information supplied in this inventory and addendum is correct and complete to the best of my knowledge.

Applicant's Signature

Date

Return completed inventory and addendum to:



Health Occupations Credentialing

Curtis State Office Building
1000 SW Jackson, Suite 330
Topeka, Kansas 66612-1365